Please read and sign below before completing this application

Requirements

A. AGE: Applicant and spouse (if spouse is also applying) must be 62 years of age at the date of application.

B. INCOME: Includes income from ALL sources for BOTH applicant and spouse. Effective July 1, 2004, the total combined applicant and spouse income must be no more than $29,205 per year, and the income for a single person must be no more than $22, 434 per year. **Income maximums change each year on July 1. Call 1-800-262-7726 or go to** www.nevadaseniorrx.nv.gov **for current income limits.**

C. RESIDENCY: Applicants must have lived continuously in Nevada for at least one year (12 consecutive months) prior to the date of application.

D. ELIGIBILITY FOR SSI/MEDICAID: If you are eligible for SSI (Supplemental Security Income) in Nevada, you are also eligible for full Medicaid benefits, including prescription coverage, at no cost to you. Please contact the Social Security Administration at **1 (800) 772-1213** if you believe your situation matches one of the following:

1) Single person, under age 65 and disabled, annual income of less than $6,768, limited assets.

2) Single person, age 65 or older, annual income of less than $7,205, limited assets.

3) Single person, blind, annual income of less than $8,080, limited assets.

4) Married couple, age 65 or older, annual household income of less than $10,500, limited assets.

Important information about your application

A. You do not need to attach income or age verification to this application. However, you may be asked to provide such documentation at a later date.

B. Married couples need to submit only one application for both spouses.

C. You will be notified of eligibility status within 21 days of receipt of your application, unless the Department of Human Resources needs to request additional information to process your application.

D. Mail completed applications to, **Senior Rx, P.O. Box 21230, Carson City, NV 89721-1230**.

By signing this application, I agree to the following:

- To immediately provide to the Department of Human Resources written notice of a change of address, name, household income, marital status, telephone number and Medicaid or SSI eligibility.
- If I received the benefit of the Senior Rx subsidies and I was not eligible for the subsidy, I will refund to the Department of Human Resources all amounts paid on my behalf.
- That as a condition of, and for purposes of determining eligibility for this program, I authorize the Department of Human Resources to verify my eligibility including my income. This authorization is valid for a period of fourteen months from the date of my signature below. Signature and date are required for this to be a valid application.

I declare the information in this application for the Senior Rx program is accurate to the best of my knowledge and ability.

Applicant Signature	Print Name	Date
Spouse Signature	Print Name	Date

Please note: If someone other than the applicant/spouse signs, a copy (non-returnable) of a Power of Attorney or Letters of Guardianship must be attached.

Nevada Department of Human Resources

Application for the State of Nevada • Senior Rx Prescription Assistance Program **Form SR Rx 7/01**

1. Applicant:_____

M ☐ **F** ☐ *Last Name, First, MI* *Birthdate* *Social Security #*

Are you Married? ☐ Yes ☐ **No** **IF YES, you must complete the following information:**

2. Spouse:_____

M ☐ **F** ☐ *Last Name, First, MI* *Birthdate* *Social Security #*

Is your spouse also applying to become a member of Senior Rx? **Yes** ☐ **No** ☐

3. Residence Address:_____

Number, Street, Apt or Space Number, City/Town, State, Zip

4. Mailing Address:_____

umber, Street, Apt or Space Number, City/Town, State, Zip.

Telephone Number: (_____) _____

6. Did you live in Nevada continuously 12 months prior to the date of this application?

Applicant Yes ☐ No ☐ **Spouse** Yes ☐ No ☐

List all current income received

Spouse must list** monthly **income even if not applying for the prescription assistance program.

		Applicant MONTHLY		Spouse MONTHLY		Total MONTHLY
7. Social Security (less Medicare)	$		+		=	
8. SSI (Supplemental Security Income)	$		+		=	
9. Pensions/IRAS	$		+		=	
10. Interest/Dividends	$		+		=	
11. Wages	$		+		=	
12. Net Real Estate Rental Income	$		+		=	
13. Other (describe)……..	$		+		=	
Total Applicant & Spouse Monthly Income	$		+		=	
14. All other income that is received quarterly, annually, etc.	$		+		=	
15. Income received year-to-date that is not listed above on lines #1-14	$		+		=	
16 Capital Gains (Loss) last year	$		+		=	
17 Business Income (Loss) last year	$		+		=	

Please provide monthly income, not annual income (except lines 14 & 15)

(Information provided on this application is confidential. No person may publish, disclose or use any personal or confidential information contained on this application except for the purposes connected with the administration of this program.)

The following information will be used by the State of Nevada for research and statistical purposes only. Your participation is voluntary and would be greatly appreciated. This information will be kept separate and confidential.

Choose one ethnic group with which you most closely identify:

☐ American Indian or Alaskan Native ☐ Black ☐ Asian/Pacific Islander ☐ Hispanic
☐ White

OUTPATIENT PRESCRIPTION DRUG INSURANCE ENROLLMENT FORM

Underwritten by Fidelity Security Life Insurance Company, Kansas City, MO.

Policy No. PD-155

Please complete enrollment form by typing or printing in ink.

State of Nevada Senior Rx Prescription Drug Plan

Member's Name:_____ Social Security Number:____/__/____

Address:_____

City:_____ State:_____

Zip:_____

Date of Birth ____/__/____ *Month Day Year*

Sex: ☐ Male ☐ Female

Phone Number:(____)_____

I understand and acknowledge that by applying for this group insurance I am also becoming a member of the United Associations of America Group Insurance Trust. The Trust is not the insurance company and has no responsibility for this insurance except to hold the master policy.

I understand and agree that the statements and answers in the application are complete and true as of the date I signed this application, and that this application becomes part of the contract of insurance. I also understand and agree that the insurance, if issued, will take effect on the effective date stated in the certificate provided this application has been accepted by the Company, the first premium has been paid in full, and that I am alive on the effective date.

Signature:_____

Date:_____

A-00935